

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certificate must be notified directly to the attending physician.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 7 3 2 6 9 4
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Owen William Bloodsworth						November 10, 1987			7:15 AM		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 12 HRS	
male		white	MONTH DAY YEAR			67 yrs		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Md.		U.S.A.					Dorchester MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN机构, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge		1210 Race St.			supervisor		Mfg.				
13a. STATE		13b. COUNTY	14. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md.		Dor.	Cambridge			YES <input checked="" type="checkbox"/>		1210 Race St. 21613			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		William	T.	Bloodsworth			Freida	Pauline	Murphy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
YES		WW II			214-10-0807		Mary A. Bloodsworth				Item 13
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DO TO, OR AS A CONSEQUENCE OF (b) Acquired Immune Deficiency			DO TO, OR AS A CONSEQUENCE OF (c)				? 5 months		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/1/87, 19, to 11/10/87, 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
Lawrence Maryanov MD.											11/10/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			610 Race St Cambridge, Md 21613						
Lawrence Maryanov MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION		CITY OR TOWN		COUNTY	STATE
cremation		11/10/87		SALISBURY CREMATORIAL		SALISBURY		WIC.			MD.
24. FUNERAL DIRECTOR		THOMAS FUNERAL HOME CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
					NOV 10 1987						

REF ID: A79150



073523 DEC 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours of death. Page 4 may be resubmitted by the hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7	3	2	6	9	5			
										REG. NO.								
1. DECEASED NAME <u>John R. Bennett</u>			FIRST <u>John</u> MIDDLE <u>R.</u> LAST <u>Bennett</u>			2a. DATE OF DEATH <u>11 25 87</u>			MONTH		DAY		YEAR		2b. HOUR <u>840 A.M.</u>			
1. SEX <u>Male</u>			4. RACE <u>white</u>			5. DATE OF BIRTH <u>6 20 19</u>			6. AGE (IN YEARS LAST BIRTHDAY) <u>68</u>			IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS HOURS <u>8</u> MIN. <u>0</u>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Ohio</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dorchester</u>			MD.						
10. CITY OR TOWN OF DEATH <u>Cambridge</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Dorchester General Hospital</u>			12a. USUAL OCCUPATION <u>Retired</u>			12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE <u>MD</u>			13b. COUNTY <u>Dorchester</u>		13c. CITY OR TOWN <u>Cambridge</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <u>903 Talisman Lane 21613</u>								
14. FATHER'S NAME <u>Royal</u>			15. MOTHER'S MAIDEN NAME <u>Grace</u>			16. SOCIAL SECURITY NO. <u>271-14-7563</u>			17. INFORMANT <u>Elsie Bonnett</u>			ADDRESS <u>Item # 13</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE DUE TO PNEUMONIA</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						(b) <u>METASTATIC CARCINOMA OF LUNG</u>						WEEKS						
						(c) <u>CARCINOMA OF LUNG</u>						WEEKS						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. <u>11</u> MONTH <u>11</u> DAY <u>21</u> YEAR <u>87</u> P.M. <u>19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <u>200 MARYLAND AVE</u> CITY OR TOWN <u>CAMBRIDGE, MD 21613</u> COUNTY <u>MD</u> STATE <u>MD</u>												
22a. I certify that (I) (this hospital) attended the deceased from <u>11/21/87</u> to <u>11/25/87</u> , that (I) (we) last saw the deceased alive on <u>11/25/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>David B. Stoekle</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>11/25/87</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DAVID B. STOECKLE MD</u>			22e. ADDRESS <u>200 MARYLAND AVE</u> <u>CAMBRIDGE, MD 21613</u>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>			23b. DATE <u>11/27/87</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>MD. VETERANS CEM.</u>			23d. LOCATION CITY OR TOWN <u>BEULAH</u> COUNTY <u>DOR.</u> STATE <u>MD.</u>									
24. FUNERAL DIRECTOR NAME <u>THOMAS FUNERAL HOME</u>			ADDRESS <u>CAMBRIDGE MD.</u>			25a. DATE REC'D. BY REGISTRAR <u>NOV 30 1987</u>			25b. REGISTRAR'S SIGNATURE <u>Julia Dandrea</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 is shown as injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 7 3 2 6 9 6					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST ROBERT		MIDDLE HARVEY		LAST CREIGHTON		2a. DATE OF DEATH		MONTH NOV	DAY 18	YEAR 1987	2b. HOUR 1050AM		
<i>Robert</i>						<i>Creighton</i>									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
MALE		CAU.		MONTH AUG. DAY 29, YEAR 1931		56		MONTHS YRS.		HOURS MIN.					
7a. BIRTHPLACE COUNTRY MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.		10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WATERMAN		12b. KIND OF BUSINESS OR INDUSTRY SHELLFISH	
13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN HONGA, CH.C.K.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21622 686 Riverside Rd., Church Ck		14. FATHER'S NAME FIRST LUTHER MIDDLE LAST CREIGHTON		15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE LAST PAUL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-34-8580		17. INFORMANT wife same as 13e, Wanda Ruark Creighton		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIOPULMONARY ARREST</i>		19. DATE OF OPERATION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <i>ACUTE M.F.</i>		DUE TO, OR AS A CONSEQUENCE OF (c)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2) 11/18, 1987, to 11/18, 1987, that (s) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (s) (we) did not view the body after death.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		CITY OR TOWN		CITY OR TOWN					
22a. I certify that (s) (we) attended the deceased from 11/18, 1987, to 11/18, 1987, that (s) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (s) (we) did not view the body after death.		22b. PHYSICIAN'S NAME Michel D. Joyce		22c. DEGREE MD.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 11/18/87							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 21, 1987		23c. NAME OF CEMETERY OR CREMATORIUM Old Trinity Cem. Church		23d. LOCATION Church Creek, Dorchester, Md.		25a. DATE REC'D BY REC'D BY NOV 20 1987							
24. FUNERAL DIRECTOR NAME CURRAN FUNERAL HOME ADDRESS 308 HIGH ST., CAMBRIDGE, MD. 21613		25b. DATE REC'D BY REC'D BY NOV 20 1987													

100-38130

NOV 5 0 1985

TO HOSPITAL OR ATTENDING PHYSICIAN

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 13 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 7 3 2 6 9 7

REG. NO.

RELEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
REEST A. Hurley SR						11	19	87	12:45 PM						
3. SEX		4. RACE	White CAUC	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS						
Male				MONTH	DAY	YEAR	79	YRS	MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		US				Dorchester Co. MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Cambridge		Dorchester General Hospital		Aluminum Salesman											
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		13f. ADDRESS							
Md.		Dor.	Cambridge	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1106 Glasgow St. 21613									
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST						
		J.	Irving	Hurley			Mary		Hubbard						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
NO		212-03-9769		Rosa Lee Hurley		Item # 13									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
IMMEDIATE CAUSE (a) Respiratory failure		months													
DUE TO, OR AS A CONSEQUENCE OF -															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Seizure		days											
{		DUE TO, OR AS A CONSEQUENCE OF		3 wks											
(c) Alcohol withdrawal				3 wks											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
Alcoholism, advancing age															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I, this hospital) attended the deceased from		10/27 1987		to		11/19 1987		that (I, we) last							
saw the deceased alive on		19		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		above. (I, we) did not view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		MEDICAL STAFF		22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								11/19/87							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE					
burial		11/22/87		DORCHESTER MEM PARK		CAMBRIDGE		DOR		MD.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
THOMAS FUNERAL HOME		CAMBRIDGE MD.		NOV 24 1987		Julia Dinkins-Pendleton									

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NOV 24 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and filed in by the funeral director, page 3 should be detached for use as the burial instructions. In please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3	7	3	2	6	9	8			
										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR			
WALTER CARL MEYER											11		6	87		7:40PM			
3. SEX		4. RACE						5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
M		white						11 14 09			77		YRS		MONTHS DAYS HOURS MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH						
Illinois		USA U.S.A.									Cambridge		Cambridge						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b KIND OF BUSINESS OR INDUSTRY							
Dor. General Hosp.		FOREMAN RETIRED										Mfg.							
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE		14. FATHER'S NAME								
MD		DORCHESTER		CAMBRIDGE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RT 3 Box 182c		FIRST Henry MIDDLE J. LAST Meyer								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS			15. MOTHER'S MAIDEN NAME								
NO		306-10-4432			WIFE			RT 3 Box 182c			Caroline								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a)										min									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										CARDIAC ARREST									
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD										4 yrs									
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
COPD, Parkinsonism																			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED								20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																			
22a. I certify that (1) this hospital attended the deceased from 5/18.1987 to 11/6.1987, that (1) (we) last saw the deceased alive on Nov 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.																			
22b. SIGNATURE		HUBERT L. FIOLEY			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		HUBERT L. FIOLEY			22e. ADDRESS					11/6/87									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY			STATE						
Cremation		11/9/87			SALISBURY CREMATORIAL			SALISBURY					MD.						
24. FUNERAL DIRECTOR NAME		ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
THOMAS FUNERAL HOME		CAMBRIDGE MD.						NOV 1 1987		John D. Danner, Esquire									

DATE ISSUED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed with the 72 hours after death.

IMPORTANT: If Item 21 is marked or if there is any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 32699											
1 - STATE REGISTRAR			REG. NO.																				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
NOV 9 1987			BERTHA			L. uovenia			MURPHY			11/12/87						15 3 PM					
4. RACE			White			5. DATE OF BIRTH			March 29, 1911			6. AGE (IN YEARS LAST BIRTHDAY)			76		YRS		IF UNDER 1 YEAR		IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			Maryland			7b. CITIZEN OF WHAT COUNTRY?			US			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Dorchester Co.			MD.		
10. CITY OR TOWN OF DEATH			Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			Dorchester General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Seamstress			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE			Maryland			13b. COUNTY			Dorchester			13c. CITY OR TOWN			Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
14. FATHER'S NAME			Howard			15. MOTHER'S M AIDEN NAME			Shorter			16. SOCIAL SECURITY NO.			Lula			17. INFORMANT			ADDRESS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			No			16b. SOCIAL SECURITY NO.			219-03-5988			17. INFORMANT			Kaye M. Rhea Item # 13			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						DUE TO, OR AS A CONSEQUENCE OF (b)			COP														
						DUE TO, OR AS A CONSEQUENCE OF (c)			DPC														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHITE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 11/12 1987</u> to <u>Nov 11/12 1987</u> , that (I) (we) last saw the deceased alive on <u>Nov 11/12 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE						DEGREE			22c. DATE SIGNED														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			VINOORAI MENTA			22e. ADDRESS			22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			11/12/87											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			Burial			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE					
24. FUNERAL DIRECTOR NAME			THOMAS FUNERAL HOME CAMBRIDGE, MD.			ADDRESS			25. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
NOV 18 1987 Julia Darden-Randall																							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1-2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, list medical conditions contributing to death.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 32700

1. DECEASED NAME (TYPE OR PRINT)	FIRST JAMES	MIDDLE SANGSTON XX.	LAST PARKS	2a. DATE OF DEATH MONTH AUG. 8, 1905	DAY YEAR 11-1-87	2b. HOUR 10:20 P.M.
3. SEX MALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH AUG. 8, 1905	6. AGE (IN YEARS LAST BIRTHDAY) 82	IF UNDER 1 YEAR MONTHS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER			MD.
10. CITY OR TOWN OF DEATH CAMBRIDGE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAFOOD PACKER		
13a. STATE MARYLAND	13b. COUNTY DORCHESTER	13c. CITY OR TOWN HOOPERSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE BOX 165, 21634		
14. FATHER'S NAME FIRST CHARLES	MIDDLE H.	LAST PARKS	15. MOTHER'S MAIDEN NAME FIRST PRISCILLA	MIDDLE FRANCES	LAST PARKS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-18-4732		17. INFORMANT (WIFE) MAGGIE M. PARKS, SAME AS # 13.	ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR		
Conditions, if any, which goe rise to immediate cause (a), stating the underlying cause lost.				DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC HEART DISEASE</u> 4 YEARS		
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <u>CHRONIC LUNG DISEASE</u> , <u>RHEUMATOID ARTHRITIS</u>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (if) this hospital attended the deceased from <u>Nov 1, 1980</u> to <u>Nov 1, 1987</u> , that (if) we last saw the deceased alive on <u>Nov 1, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if) we did not view the body after death.						
22b. SIGNATURE <u>Michael A. Moskewicz MD</u>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11-1-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael A. Moskewicz MD</u>	22e. ADDRESS 503 BYRN ST. CAMBRIDGE MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 11-04-87	23c. NAME OF CEMETERY OR CREMATORIAL DORCHESTER MEM. PK.	23d. LOCATION CITY OR TOWN CAMBRIDGE, DORCHESTER, MD.			
24. FUNERAL DIRECTOR NAME CURRAN FUNERAL HOME,	ADDRESS 21613	25a. DATE REC'D. BY REGISTRAR NOV 4 1987	25b. REGISTRAR'S SIGNATURE <u>Suzie Sartorius-Randall</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 may be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 will be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8732701

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST DELLA MIDDLE DUNN LAST PHILLIPS	2a. DATE OF DEATH	MONTH NOV.	DAY 9	YEAR 1987	2b. HOUR 5:40 a.m.
SEX female				4. RACE cau.	5. DATE OF BIRTH MONTH NOV. DAY 24, YEAR 1905	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.			
10. CITY OR TOWN OF DEATH CAMBRIDGE				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL				12a. USUAL OCCUPATION SECRETARY	
13a. STATE MARYLAND				13b. COUNTY DORCHESTER	13c. CITY OR TOWN CAMBRIDGE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 201 High St. 21613	
14. FATHER'S NAME FIRST ERNEST MIDDLE McCLELLAND LAST DUNN				15. MOTHER'S MAIDEN NAME FIRST MINNIE MIDDLE LAST Gould					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214-07-9313	17. INFORMANT Cambridge, Md. 21613 ADDRESS William P. Asplen, Jr., 209 Washington St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>astro carcinoma common bile duct</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION Sept 1987		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Above				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug 19 87 to Nov 9 87, that (I) (we) last saw the deceased alive on Nov 8 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Lewis M Burdette M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Nov 8 1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis M Burdette		22e. ADDRESS 4 Aurora St Cambridge, Md. 21613							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 11/12/87		23c. NAME OF CEMETERY OR CREMATORIALY Dorchester Mem. Pk. Airey, Cambridge, Dor., Md.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Cambridge, Md. 21613 Curran Funeral Home, 308 High St.				25a. DATE REC'D. BY REGISTRAR NOV 12 1987		25b. REGISTRAR'S SIGNATURE <i>Julia S. Burdette</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 8732703													
1 - FOR STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR		2b. HOUR 9:30 P.M.		
RAY			W ROACH			NOV 2 1987							
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		Caucasian		04 25 98			70		YRS		MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER COUNTY MD.				
Rochester, N.Y.		U.S.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE		12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge		Cumbridge House		Bal + Disc. Makers			NO		520 GLENBURN AVE. 21613		Automotive		
13. STATE Maryland		13a. COUNTY Dorchester		13c. CITY OR TOWN			14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
							SAMUEL W. ROACH		MARY JANE MOREY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
YES		169-01-8782		JOHN McDERMOTT - nephew 320 ANDIRON LANE - ROCHESTER, N.Y.			Myocardial Infarction		14612 1 month				
							DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis		2 years				
							DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
19b.													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN			COUNTY STATE			
22a. I certify that <input type="checkbox"/> (his hospital) attended the deceased from saw the deceased alive on <input type="checkbox"/> 11-2 1987, and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (he) (she) (did) (did not) view the body after death.		22b. SIGNATURE Michael A. Moskowicz MD			22c. DEGREE		22d. DATE SIGNED 11-2-87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 503 BYRN ST. CAMBRIDGE MD 21613						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. DATE OF DEATH REMOVED 23f. DATE OF REMOVAL 23g. DATE OF Cremation				
Removal		11-2-87					NOV 03 1987						
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE OF DEATH REMOVED 25b. DATE OF REMOVAL 25c. DATE OF Cremation								
State Anatomy Board		Balto., Md.											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please attach carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other traumatic event, the medical examiner must be notified of same.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 7 3 2 7 0 4							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
FLOSSIE				T. Jones			S. SIMMONS			Aug 28, 1907				1987	7:50P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH						16. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Female		White		Month			Day			80		MONTHS		DAYS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			YEAR			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.							
Maryland		US		MARRIED <input type="checkbox"/>			NEVER MARRIED <input type="checkbox"/>			Dorchester Co.									
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>																	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge		Dorchester General Hospital										Seamstress							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland		13b. COUNTY		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/>		NO <input type="checkbox"/>		409 Cemetery Ave. 21613									
Dorchester		Cambridge																	
14. FATHER'S NAME		FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME								
Ward					Hughes						Ada								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		213-24-4730		Shirley Niblett		415 Kent St.		Cambridge, Md. 21613											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION												2 hours							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												6 hours							
DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION												4000s							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
/												YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
		P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE						
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <input type="checkbox"/> NOV 9, 1987, to <input type="checkbox"/> NOV 9, 1987, that <input type="checkbox"/> (we) lost saw the deceased alive on <input type="checkbox"/> NOV 9, 1987, and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.																			
22b. SIGNATURE		DEGREE										22c. DATE SIGNED							
Michael A. Moselewicz												NOV 9, 1987							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS								
Michael A. Moselewicz											503 BURN ST. CAMBRIDGE MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE								
Burial		11/12/87		Dor Mem Park			Cambridge		Dor		Md.								
24. FUNERAL DIRECTOR NAME		ADDRESS										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
THOMAS FUNERAL HOME		CAMBRIDGE, MD.										NOV 1 1987		Dorothy Rundall					

BP _____

038082 1011201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 1 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate should be detached.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR	
DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			11 1 87 2:36 P	
DOLLIE A. SMULLEN													
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
F			BLACK			MONTH DAY YEAR			65			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Md.			USA						Dorchester				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
CGE			JGH.										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
MD			DOR			CGE						816 ROBBINS St. 21613	
14. FATHER'S NAME			15. MOTHER'S M AIDEN NAME										
Roy			IDA. M. L. ROU NCE										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
+			217-12-4360			(Spouse) William C. Smullen						21613	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROFOUND CARDIAC COLLAPSE MIN													
DUE TO, OR AS A CONSEQUENCE OF (b) ANEMIA.													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.													
DUE TO, OR AS A CONSEQUENCE OF (c) P. VERTA													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. CHE. PVD; Hypertension, DIABETES, Aortic Stenosis													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
-			-			-			-				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSED DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			-				
-			-			-			-				
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE	
-			-			-			-				
22a. I certify that (I) this hospital attended the deceased from 10-1-87 to 11-1-87, that (I) (we) last saw the deceased alive on 19-1-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN			22c. DATE SIGNED				
Anne R. WILKE									11-1-87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
Anne R. WILKE			400 MD AVE; CGE MD 21613										
23a. BURIAL, CREMATION, REMOVAL (CITY) Burial			23b. DATE 11/5/87			23c. NAME OF CEMETERY OR CREMATORIAL Bethel AME Cem.			23d. LOCATION CITY OR TOWN Camb.,			COUNTY STATE	
-			-			-			-				
24. FUNERAL DIRECTOR NAME L.H. Boa rdley F/H Cambridge, Md. 21613			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 05 1987			25b. REGISTRAR'S SIGNATURE Julia Sanderson-Lindner				

NO-11715150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician indicate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the physician. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked deceased [] shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 32706		
										REG. NO.		
072230	NOV	88	DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Edward			Weeks		M	Weeks	Nov	14	87	5:17 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH							6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS MONTHS	
male	Black	MONTH DAY YEAR 6 8 1916							71	YRS.	MONTHS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia	U. S.							Dorchester	MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Cambridge	Dorchester General						12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE IF HAVING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION												
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE			
Md.	Dorchester	Hurlock							1071 Box 202 F	21643		
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						FIRST	MIDDLE	LAST
Benjamin			Weeks	Nora						Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS						18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
No	328-24-2220	Oneida Weeks	1071 Box 202 F						Respiratory Arrest			2 minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.												
DOUE TO, OR AS A CONSEQUENCE OF (b) Vomiting and internal bleeding												
DOUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Prostatic Carcinoma												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE					
22a. I certify that (1) (this hospital) attended the deceased from Nov 12, 1987, to Nov 14, 1987, that (1) (we) lost saw the deceased alive on Nov 14, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we did) (did not) view the body after death.												
22b. SIGNATURE	DEGREE						22c. DATE SIGNED					
Edmund J. MacLaughlin							11/14/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS											
Edmund J. MacLaughlin	10 Aurora St. Cambridge, Md 21613											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN									
Burial	11-19-87	Mt Zion	Bethel Caroline Md.									
24. FUNERAL DIRECTOR NAME	ADDRESS						25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
Bennie J. Smith	P.O. Box 928						NOV 17 1987				Julia Bender-Randall	

TO GET YOU ACCESS TO

TO GET YOU NOW